Lacrosse Encephalitis

Investigator:

Agency: Phone number:

FOR STATE USE ONLY

Status: ☐ Confirmed ☐ Suspect ☐ Probable ☐ Not a case

Reviewer initials:

Referred to another state:

CASE

Last name: ______ Date of Birth: __/__/__ Estimated? ☐ Age: ______

First and middle name: ______

Gender: ☐ Female ☐ Male ☐ Other ______

Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: __/__/__

Maiden name: ______ Suffix: ______

Marital status: ☐ Single ☐ Married ☐ Parent with partner ☐ Separated ☐ Widowed

Address line: ______

Zip: ______ City: ______

Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ Asian

State: ______ County: ______

Long-term care resident: ☐ Yes ☐ No ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Facility name: ______ Parent/Guardian name: ______

Facility phone: ( )- - Type: ______ Parent/Guardian phone: ( )- - Type: ______

EVENT

Onset date: __/__/__ Diagnosis date: __/__/__

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Outbreak name: ______

Exposure setting: ______

Epi-linked: ☐ Yes ☐ No ☐ Unknown

Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown

State: ______ Country: ______

Healthcare provider information

Last name: ______

First name: ______

Provider type: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA

Facility name: ______

Address line 1: ______

Address line 2: ______

Zip code: ______ City: ______

State: ______ County: ______

Phone : ( )- - Type: ______

LABORATORY FINDINGS

Laboratory: ______ Specimen source: ______ Test type: ☐ Serology (ELISA) ☐ PCR ☐ Other ______

Accession #: ______ Result date: __/__/__ Result type: ☐ Preliminary ☐ Final

Collection date: __/__/__ Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG Result: ☐ Negative ☐ Positive ☐ Equivocal ☐ Indeterminate

Date received: __/__/__ Organism: **Lacrosse virus** Type:

Laboratory: ______ Specimen source: ______ Test type: ☐ Serology (ELISA) ☐ PCR ☐ Other ______

Accession #: ______ Result date: __/__/__ Result type: ☐ Preliminary ☐ Final

Collection date: __/__/__ Test type: ☐ Acute ☐ Convalescent ☐ IgM ☐ IgG Result: ☐ Negative ☐ Positive ☐ Equivocal ☐ Indeterminate

Date received: __/__/__ Organism: **Lacrosse virus** Type:

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Date received: __/__/__ Organism: **Lacrosse virus** Type:

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / _____ Address: _____

Date worked to: / / _____ Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / _____ Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / _____ Address: _____

Date worked to: / / _____ Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / _____ Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: / / _____ Discharge date: / / _____ Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type: _____

CLINICAL INFO & DIAGNOSIS

Physician diagnosis:
☐ Encephalitis
☐ Meningitis
☐ Meningoencephalitis
☐ Fever
☐ Asymptomatic
☐ Hepatitis/jaundice
☐ Multi-system organ failure
☐ Other _____
☐ Dengue hemorrhagic fever/ Dengue shock

Clinical classification:
☐ Neuroinvasive
☐ Non-neuroinvasive

Symptoms:
☐ Acute flaccid paralysis
☐ Altered mental state
☐ Anorexia
☐ Coma
☐ Confusion
☐ Cranial nerve palsies
☐ Diarrhea
☐ Double vision
☐ Eye pain
☐ Fatigue
☐ Fever
☐ Gait/balance difficulty
☐ Headache
☐ Joint pain
☐ Muscle pain
☐ Nausea
☐ Photophobia
☐ Rash
☐ Stiff neck
☐ Swollen lymph nodes
☐ Tremors
☐ Vertigo
☐ Vomiting
☐ Other symptoms: _____

Pre-existing Conditions

Before your West Nile virus (WNV) infection, did a health care provider ever tell he/she had any of the following medical conditions?

☐ Diabetes
☐ High blood pressure (hypertension)
☐ Heart attack (myocardial infarction)
☐ Angina or coronary artery disease
☐ Congestive heart failure
☐ Stroke
☐ Chronic obstructive pulmonary disease (COPD)
☐ Chronic liver disease
☐ Kidney disease or failure
☐ Bone marrow transplant
☐ Alcoholism
☐ Case had none of the conditions listed

Before WNV infection, did the case ever have a solid organ transplant? ☐ Yes ☐ No ☐ Unk

If yes, what organ was transplanted: _____

If yes, what year was the transplant: _____

Before WNV infection, has the case ever had cancer? ☐ Yes ☐ No ☐ Unk

If yes, what cancer type(s): _____

If yes, what year were you diagnosed: _____

If yes, are you currently being treated for cancer: ☐ Yes ☐ No ☐ Unk

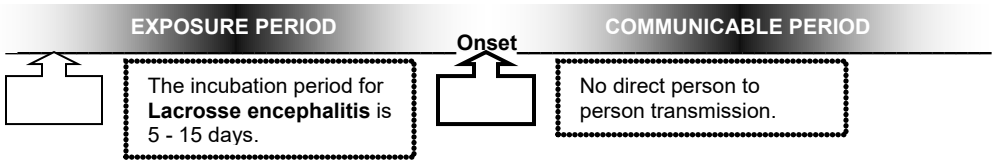
Before WNV infection, did the case have any medical condition that limited his/her ability to fight infection? ☐ Yes ☐ No ☐ Unk **If yes, what condition:** _____

At the time WNV infection was diagnosed, was the case taking any of the following types of prescription medications or treatments?

☐ Chemotherapy	☐ Oral or injected steroids	☐ Medications to treat coronary artery disease
☐ Other treatments for cancer	☐ Inhaled steroids	☐ Medications to treat congestive heart failure
☐ Hemodialysis	☐ Insulin or other medications to treat diabetes	☐ Medications that suppress the immune system
☐ Other treatments for kidney disease	☐ Medications to treat high blood pressure	☐ Case was not on any medication/treatments listed

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Ever vaccinated for Yellow Fever or Japanese encephalitis (JE)? ☐ Yes ☐ No ☐ Unknown

If yes, list MOST RECENT vaccination information ONLY:

Disease:	☐ Yellow fever ☐ JE	Disease:	☐ Yellow fever ☐ JE
Date vaccinated:	/ /	Date vaccinated:	/ /
Lot #:		Lot #:	
Vaccine type:		Vaccine type:	
Manufacturer:		Manufacturer:	

Number of vaccinations: ____

Risk Factors/Travel Information

In the 15 days prior to onset of symptoms did the case:

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk — City in Iowa: _____ — Departure date: / / — Return date: / /

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk — State: _____ City: _____ — Departure date: / / — Return date: / /

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk — Country: _____ — Departure date: / / — Return date: / /

Exposed to mosquitoes: ☐ Yes ☐ No ☐ Unk

Use a mosquito repellent: ☐ Yes ☐ No ☐ Unk If yes, how often? ☐ Sometimes ☐ Never ☐ Always ☐ Most of the time If yes, what type? ☐ Picaridin ☐ DEET ☐ Oil of lemon eucalyptus ☐ Other _____

If the patient is female, was she:

Pregnant? ☐ Yes ☐ No ☐ Unk

Breastfeeding? ☐ Yes ☐ No ☐ Unk

In the 30 days prior to onset of symptoms did the case:

Donate blood, blood products, organs or tissues? ☐ Yes ☐ No ☐ Unk Date donated: / /

Receive blood or blood products? ☐ Yes ☐ No ☐ Unk Date received: / /

Receive organs or tissue? ☐ Yes ☐ No ☐ Unk Date received: / /

Case acquired infection: ☐ Naturally ☐ Transplantation ☐ Transfusion ☐ Trans-placental ☐ Breastfeeding ☐ Occupationally ☐ Unknown

NOTES: _____